ADS CENTER

SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health

Addressing the Challenges of Medical Providers in Treating Persons with Mental Health Issues

September 16, 2008

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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*The Moderator for this call is **Michelle Hicks**.*

Disclaimer

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Questions?

At the end of the speaker presentations, you will be able to ask questions. You may submit your question by pressing '01' on your telephone keypad. You will enter a queue and be allowed to ask your question in the order in which it was received. On hearing the conference operator announce your name, you may proceed with your question.

Speakers

Benjamin G. Druss, M.D., M.P.H.

As the first Rosalynn Carter Chair in Mental Health at Emory University, Dr. Druss is working to build linkages between mental health and broader public health and health policy communities. Dr. Druss has published more than 100 peer-reviewed articles largely focusing on the policy and systems issues on the interface between primary care and mental health. He has received several national awards for his work, including the 2000 American Psychiatric Association Early Career Health Services Research Award, the 2000 AcademyHealth Article-of-the-Year Award, and the AcademyHealth 2003 Alice S. Hersh New Investigator Award. In 2006, was the recipient of a five-year Career Award from the National Institute of Mental Health titled "Mending the Public Safety Net: Improving Linkages Between CHCs and CMHCs."

Speakers

Dally Sanchez

Ms. Sanchez is currently the coordinator of YOUTH POWER! the statewide youth network of Families Together in New York State. She is a 27 year-old, Latina suicide and trauma survivor who has been an advocate for 12 years. Formerly from Westchester County, NY Youth Forum, Ms. Sanchez began her career in this group as a member, and then became a peer leader and eventually co-coordinator and office manager for the group. She also has been a part of the national and statewide youth movement for the last ten years. Ms. Sanchez attended and participated in the 2001 SAMHSA Systems of Care community planning meeting and the 17th Annual Rosalynn Carter symposium on children's mental health. She is a member of the New York Association for Psychiatric Rehabilitation Services Board of Directors as Co-chair of the Cultural Competency Committee, the New York State Multicultural Advisory Committee to the Commissioner of the Office of Mental Health and the New York State Recipient Advisory committee to the Commissioner of the State Office of Mental Health. Ms.Sanchez also serves on the ADS Center Steering Committee.

Speakers

Anthony T. Ng, MD

Dr. Ng is an Assistant Professor of Psychiatry at the Uniformed Services University of Health Sciences and the George Washington University School of Medicine. He is a board-certified psychiatrist and a director of Mannanin Healthcare, LLC, a health care consulting firm and a medical officer with the DC Department of Mental Health Comprehensive Psychiatric Emergency Program (CPEP).He is the current President of the American Association of Emergency Psychiatry as well as being a member of the boards of the American Association of Community Psychiatrists and Mental Health America. He has a lengthy history of involvement and advocacy in community mental health issues and extensive experience in the area of primary care and mental health, cross cultural issues, community system issues, substance abuse and homeless issues. He is also involved in community mental health and disaster mental health.

Addressing the Challenges of Providers in Treating Persons with Mental Health Issues

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Mental Illness and Medical Illness

- Measures of emotional distress were stronger correlates of patient-rated distress from coronary artery disease (CAD) due to the symptoms than were traditional risk factors

Ketterer MW et al., *Psychosomatics.* 2008.

- Among women with suspected myocardial ischemia, a combination of depressive symptom severity and treatment history was a strong predictor of an elevated CAD risk profile and increased risk of cardiac events compared with those without depression or with only 1 of the 2 measured depression markers

Rutledge T, et al., *Arch Gen Psych,* 2006.

Mental Illness and Medical Illness

- Among patients with coronary disease, depressive symptoms are strongly associated with patient-reported health status, including symptom burden, physical limitation, quality of life, and overall health.

Ruo B, *JAMA,* 2003.

- Nearly half of asthma patients in this study had a positive screen for depressive symptoms. Asthma patients with more depressive symptoms reported worse health-related quality of life than asthma patients with similar disease activity but fewer depressive symptoms.

Mancuso CA, *J Gen Intern Med,* 2000.

Mental Illness and Medical Illness

- 25% of adults with obesity and physical illness had a mental illness
- Average total expenditures for obese adults with physical illness and mental illness were $9897
- Average expenditures were $6584 for those with physical illness only
- Mean pharmacy expenditures for obese adults with physical illness and mental illness and for those with physical illness only were $3343 and $1756, respectively.

Shen C et al. *Dis Manag, 2008.*

Mental Illness and Medical Illness

- Total average expenditures (fiscal year 2000) were lowest ($6,185) in the "No MI and No SUD"
- Highest ($19,801) for individuals with schizophrenia/other psychoses and alcohol/drug use
- High expenditures were associated with both SUD and MI conditions in diabetes patients
- Veterans with alcohol/drug use had the highest expenditures across all groups of MI.

Banerjea R et al. *J Beh Health Serv Res,* 2008.

Mental Illness and Medical Illness

- People who reported mental disorders were twice as likely to report having been denied insurance because of a preexisting condition or having stayed in their job for fear of losing their health benefits then those who do not report mental disorders
- Among respondents with insurance, those who reported mental illness were no less likely to have a primary care provider but were about two times more likely to report having delayed seeking needed medical care because of cost or having been unable to obtain needed medical care.

Druss BG & Rosenheck RA. *Am J Psych*, 1998.

Mental Illness and Primary Care

- At least ½ to as much as 85 % of common mental health disorders are tx'ed in general medical settings by non-mental health providers.

President's New Freedom Commission on Mental Health. 2003.

Rabasca, L. APA Monitor Online, 1999.

- PCP write about 20% of the antipsychotics filled in pharmacy
- 18% increase in antipsychotics since 1996 when use of atypicals became widespread

Kapur S, et al. *Am J Psych*, 2001.

Mental Illness and Primary Care

- Persons with psychotic disorders and bipolar disorder reported markedly more difficulty in obtaining a primary care physician and greater barriers to care than the general population.

Bradford DW et al. *Psych Serv*, 2001.

- Patients with psychiatric disorders experience stigmatization in their attempts to access health care. This stigma may have a greater impact than race and ethnicity, thereby leading to a similarity in perception of health care between minorities and non-minorities with mental illness.

Roman JS et al. *J Cult Divers*, 2008.

Reality of Mental Health Care

- Increased needs and demands
- Insufficient and confusing access
- Primary care providers being front line
- Persistent stigma
- Lack of parity

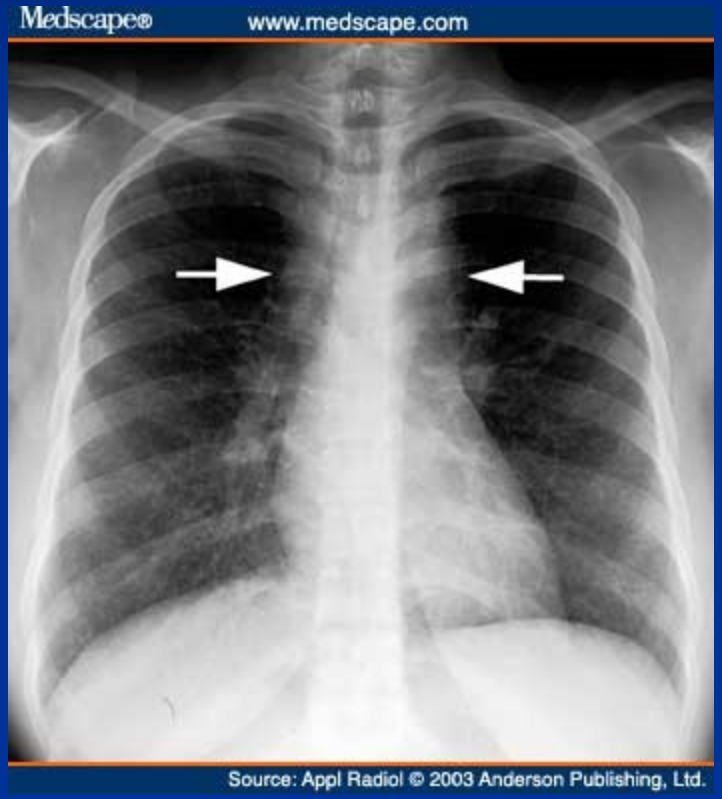
Awareness  Understanding

Challenges

- Intrinsic (How you see it)
  - Stigma
  - Priority
- Extrinsic (How others see it)
  - Stigma
  - Priority

Stigma

- Education
- Culture/spiritual beliefs
- Personal experiences
- Community acceptance
- Perception of helplessness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Perceptions of Mental Health Tx

What to Do?

- Patient education
- Patient empowerment
- Provider education
- Community education
- User friendly access
- Realistic goals
- Advocacy for parity

Treating The Person Not A Diagnosis

By Dally M. Sanchez
Psychiatric Survivor and Activist
Albany, NY
SAMHSA ADS Center
September 16th 2008

My Experiences and Perspective

- I am not my label
- The cost of a bad experience
- Treating with dignity and respect builds a mutually beneficial doctor/ patient relationship

Treat The Whole Person

- See the individual and their unique circumstances
- Look at all aspects of a person's health
  - Mind
  - Body
  - Spirit

Listen Without Judgment

- Leave assumptions at the door
- Ask questions
- Listen with an open mind

Culture Is Always Relevant

- Understand cultural beliefs
- Treat with the person's cultural values in mind
- Culture is beyond color

Caring, Compassion, and Understanding

- Leave and breathe these values
- Caring is the driving force
- Compassion makes it possible to connect
- Understanding creates empathy

Improving Primary Medical Care for Mental Health Consumers

Benjamin Druss MD, MPH

September 16, 2008

Overview

- Defining the problem
- A public health approach to addressing it
- Current initiatives

The Problem: Medical Illness and Premature Mortality in the Public Mental Health Sector

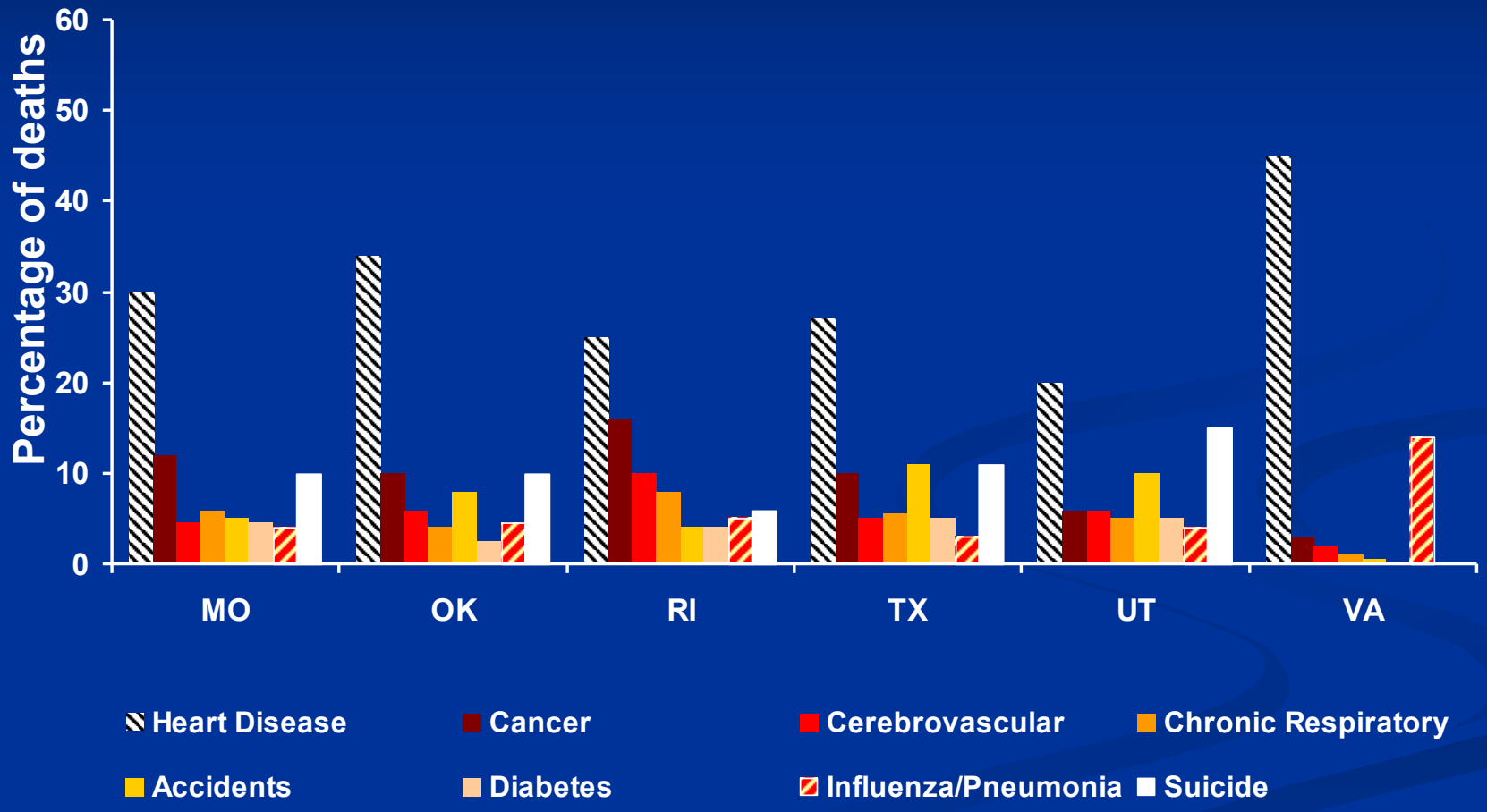
Mortality Associated with Mental Disorders: Mean Years of Potential Life Lost

Year	AZ	MO	OK	RI	TX	UT
1997		26.3	25.1		28.5	
1998		27.3	25.1		28.8	29.3
1999	32.2	26.8	26.3		29.3	26.9
2000	31.8	27.9		24.9		

Compared with the general population, persons with major mental illness lose 25-30 years of normal life span

Colton CW, Manderscheid RW. Prev Chronic Dis [serial online] 2006 Apr [date cited]. Available at: URL:http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

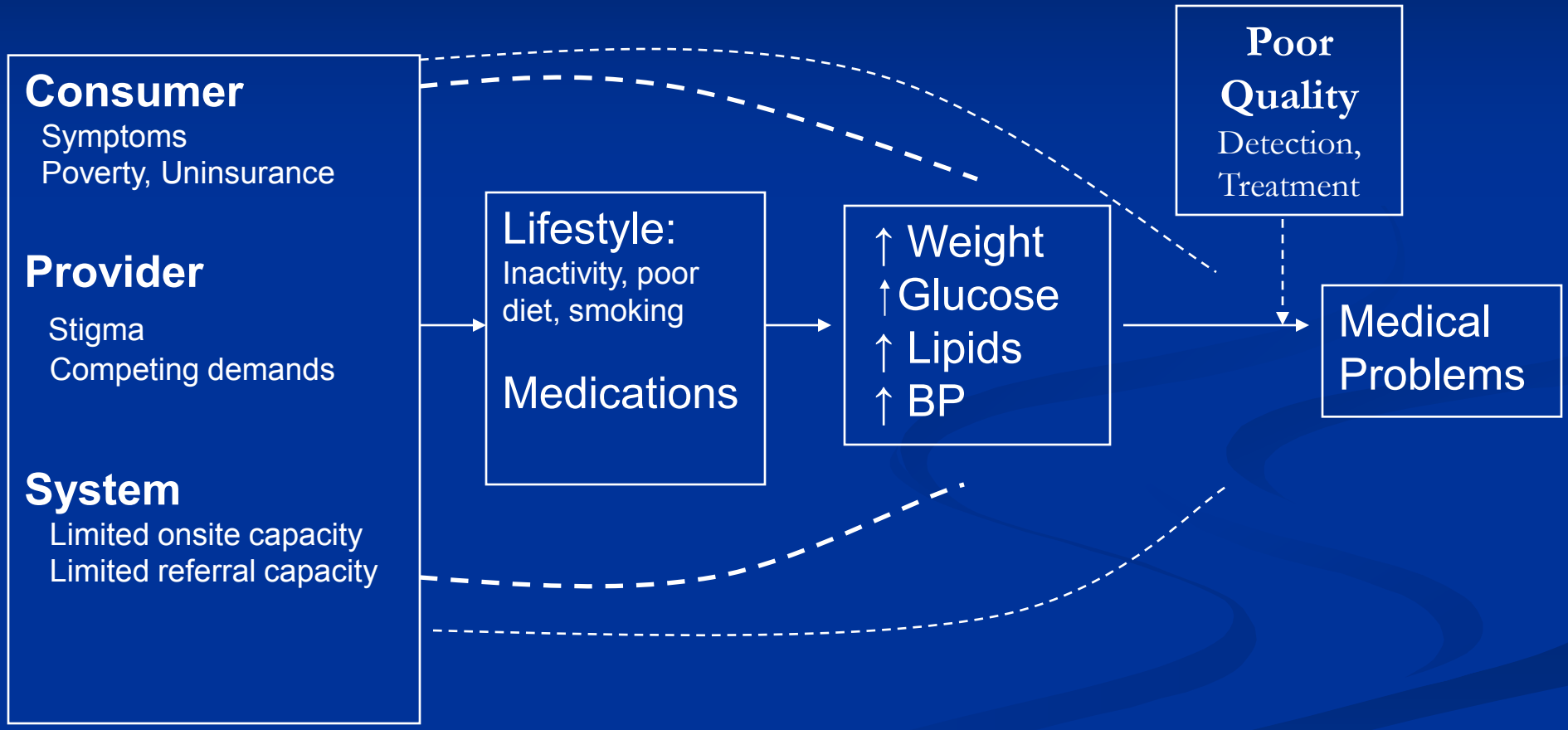
Cardiovascular Disease Is Primary Cause of Death in MH Consumers*



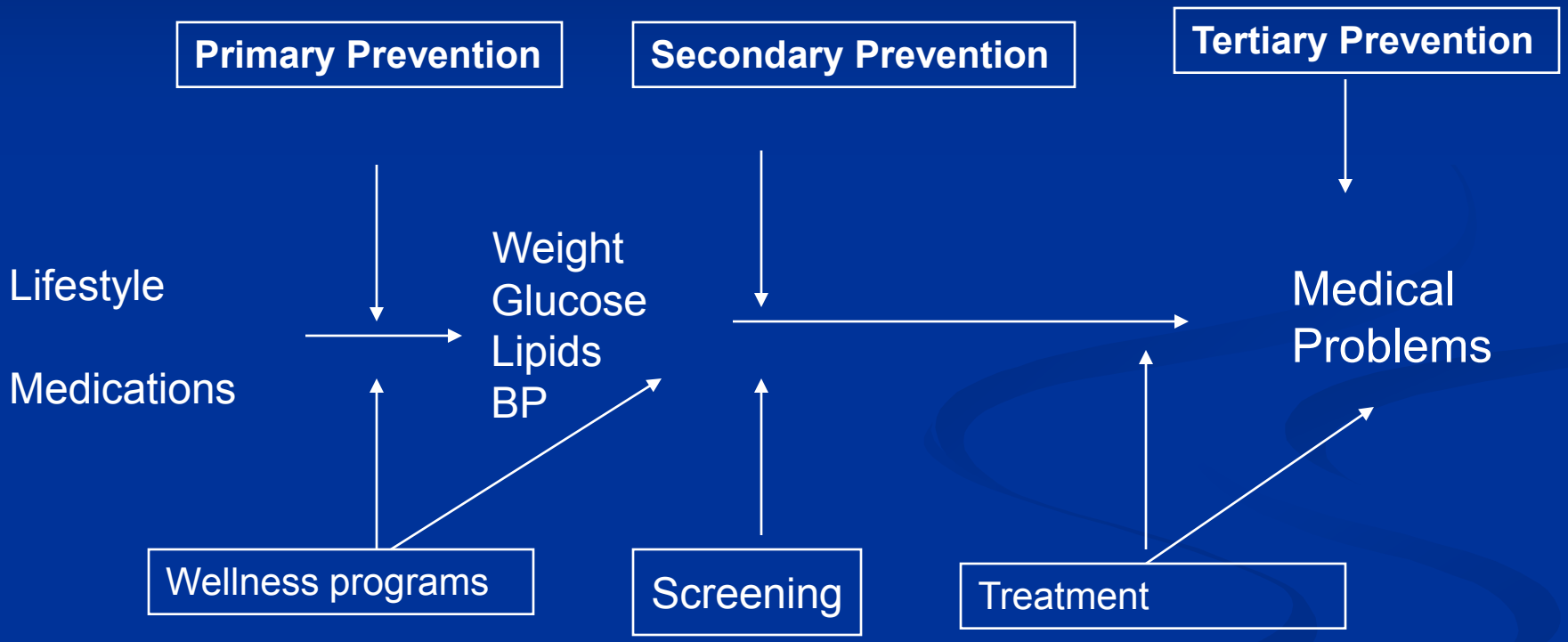
*Average data from 1996-2000.

Colton CW, Manderscheid RW. Prev Chronic Dis [serial online] 2006 Apr [date cited]. Available at URL: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

Causes of Morbidity and Mortality in MH Consumers



Addressing Risk Factors



The Heart of Primary Care: The Four C's

- First Contact: Provider is where individuals seek entry to the health system
- Comprehensiveness: Care addresses most personal health needs
- Continuity: Care is organized across time: PCP remains the principal source of care.
- Coordination: Care is organized across space: providers, clinics and organizations.

How Well Are We Doing?

2007 Survey of NCCBH members:

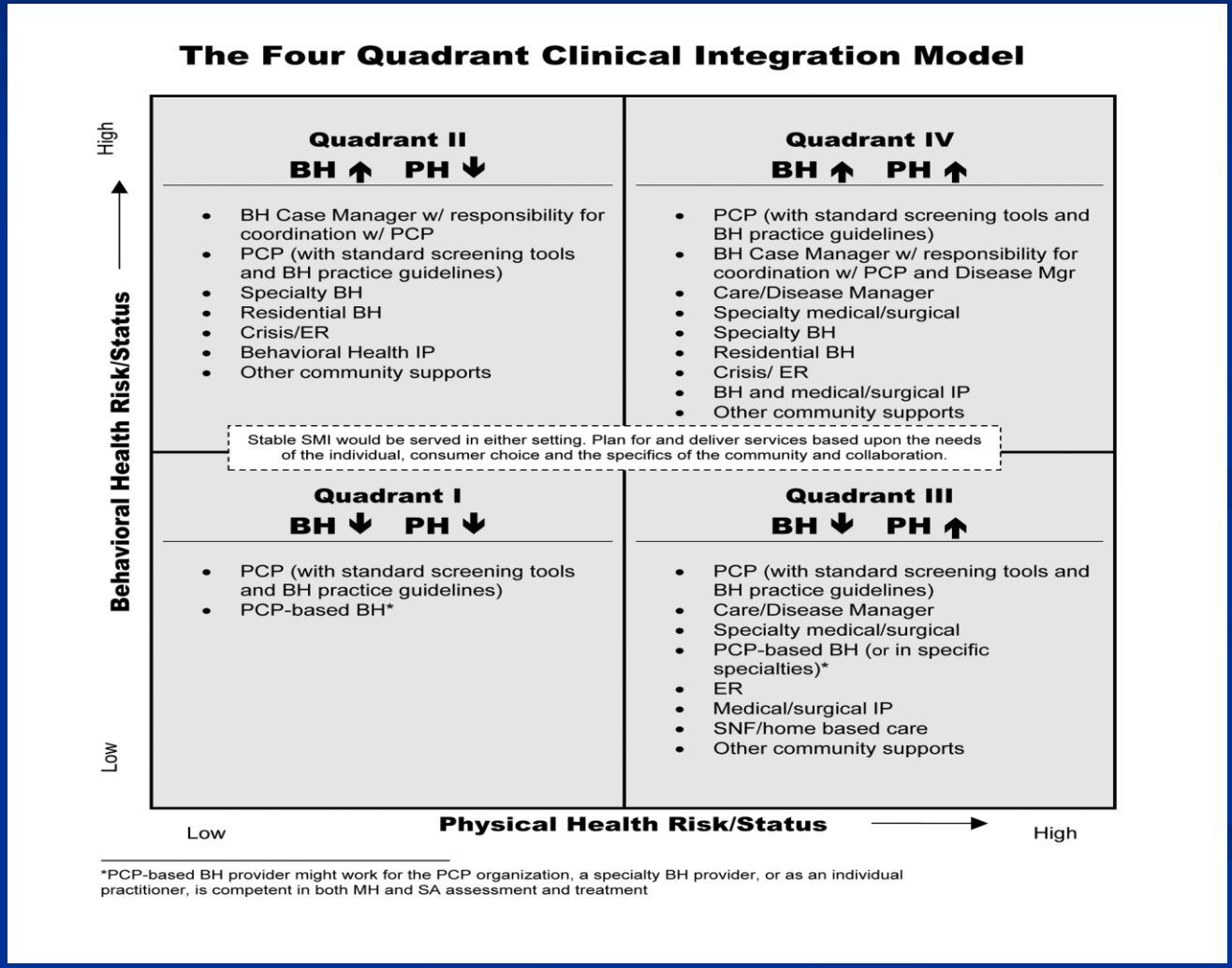
- Capacity to Screen and Provide Care:
  - 2/3 have capacity to screen for common medical problems.
  - 1/2 can provide treatment or referral for those conditions
  - 1/3 can provide some medical services onsite
- Barriers to providing general medical services: Problems in reimbursement, workforce limitations, physical plant constraints, and lack of community referral options.

Druss BG et al 2008 Psychiatric Services

Challenges for Consumers in Obtaining Primary Medical Care

- MH Consumers often report challenges in developing ongoing relationships with PCPs.
- Why is this the case?
  - The state of primary care in the United States, particularly in the public sector
  - Issues such as stigma that are specific to MH consumers

Where Should Care Be Delivered? The 4 Quadrant Model



Quadrant II

Quadrant II

BH↑ PH↓

- Population-based care in MH settings
- Primary prevention (wellness activities) and secondary prevention (screening for glucose, lipids, high blood pressure etc)

Quadrant IV

Quadrant IV

BH↑ PH↑

- Requires both MH and medical care, as well as a mechanism for coordinating care between them
- Care can be provided either **onsite** (collocated) or in the community with care management

Examples of Approaches for Improving Health and Healthcare for MH Consumers

Example 1: Training Consumers

- Research: The HARP project (Health and Recovery Peer Project): An NIMH-funded study to adapt a peer led medical Self-Management Program for MH Consumers in Atlanta GA.[1]
- Real World: "In Shape" Program in New Hampshire: physical fitness and weight loss program for MH consumers using community resources (e.g. YMCA membership)

Funded by NIMH R34MH078583

Example 2: Collocated Care

- Research: The Integrated Care Clinic: A multidisciplinary team provided medical care for veterans with SMI. The intervention was associated with improved access, quality, and medical outcomes.[1]

- Real World: Cherokee Health Systems in Tennessee is a CMHC that became an FQHC; it provides integrated, collocated medical and mental health care

1. Druss et al: Arch Gen Psychiatry. 2001;58(9):861-8.

Example 3: Referral and Care Management

- Research: The PCARE (Primary Care Access, Referral, and Evaluation) study: An NIMH-funded trial of medical case management for consumers at an Atlanta CMHC.
- Real World: Georgia's Medicaid Disease Management Program, APS, is the first in the country to manage all the comorbid problems of people with particular conditions (including schizophrenia) rather than just the conditions themselves.

Funded by NIMH R01MH070437

Addressing Stigma Among Primary Care Physicians

- Primary care physicians share the same sorts of stigma in the general public; preconceptions and lack of personal knowledge of MH consumers.
- Meeting and working with MH consumers may help reduce stigma among PCPs.
- It may be possible to identify and train PCPs who specialize in working with MH consumers.

Policy Initiatives

- *Advocacy groups: "10 in 10" Campaign* Advocacy groups and governmental agencies have committed to reducing the mortality gap for persons with SMI
- *States:* 2006 NASMHPD Medical Directors Morbidity and Mortality Report helped mobilize states to begin screening and treatment programs
- *Federal:* CMHC Improvement act would provide $50 million each year to fund collocated primary services in the nation's CMHCs.

Local Consideration in Choosing Care Models

- *Community Resources:* What are the medical referral options in the community?
- *Onsite Medical Capacity:* are there qualified staff onsite who can deliver primary care services?
- *Reimbursement Factors:* Who will pay for the services?
- *Consumer Preferences*—Are people more likely to accept care in primary care or specialty settings?

Conclusions

- Excess morbidity and mortality in persons with SMI is a public health crisis
- Reducing the epidemic of excess mortality in MH consumers will require policy changes at multiple levels
- In the meantime, local providers and communities must be creative in developing programs that are consistent with their local resources and needs.

Resources

Bazelon Center for Mental Health Law. (2004). Get it Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders
http://www.bazelon.org/issues/mentalhealth/publications/getittogether/

Building Bridges: Mental Health Consumers and Primary Health Care Representatives in Dialogue
http://download.ncadi.samhsa.gov/ken/pdf/SMA06-4040/Policy_Makers_Booklet.pdf

The Pledge for Wellness - *Take action to prevent and reduce early mortality by 10 years over the next 10 year time period*
http://www.bu.edu/cpr/resources/wellness-summit/pledge.html

Survey

We value your suggestions. Within 24 hours of this teleconference, you will receive an e-mail request to participate in a short, anonymous online survey about today's training material. Survey results will be used to determine what resources and topic areas need to be addressed by future training events. The survey will take approximately five minutes to complete.

Survey participation requests will be sent to all registered event participants who provided e-mail addresses at the time of their registration. Each request message will contain a Web link to our survey tool. Please call **1-800-540-0320** if you have any difficulties filling out the survey online. Thank you for your feedback and cooperation.

Written comments may be sent to the Substance Abuse and Mental Health Services Administration (SAMHSA) ADS Center via e-mail at promoteacceptance@samhsa.hhs.gov.